WILLAMETTE VALLEY ENDOCRINOLOGY

Martin L. Bassett, M.D., P.C.
Tauni Carter PA-C.
Kristen Gehring, P.A.-C.
JesAnne Tageson-Ramirez, P.A.-C.
Christopher Killen, PA-C

Dear _____:

You are scheduled for a consultation in our office with

_____ Martin L. Bassett, M.D., P.C.
_____ Tauni Carter, PA-C
_____ Christopher Killen, PA-C
_____ Kristen Gehring, PA-C
_____ JesAnne Tageson-Ramirez, PA-C

on _____, _____ at _____ am / pm.
Please **check-in** to your appointment at _____ am / pm.

If you are not able to make this appointment, call our office 72 hours (3 days) in advance prior to your appointment to avoid a $75 charge.

Please complete this packet and bring it to your appointment, along with your insurance card(s) and your picture identification.

PLEASE NOTE: <u>COPAYS are DUE at the time of service</u>.

Our office is located at
925 Commercial St. S.E., Suite 320, Salem, OR 97302
Phone: (503) 399-8105 Fax: (503) 585-5351

<u>Heading SOUTH on I-5</u>
Take **Exit 253** to **Hwy 22/99E/Mission St SE** and turn **right**.
Continue on **Mission St**. to **Commercial St SE** (stay in far right hand lane)
Turn **left** on **Commercial St SE**.
Turn **right** one block at **925 Commercial St SE** (immediately after Kearney St. S.)

<u>Heading NORTH on I-5</u>
Take **Exit 253** to **Hwy 22/99E/Mission St SE** and turn **left**.
Continue on **Mission St**. to **Commercial St SE** (stay in far right hand turning lane)
Turn **left** on **Commercial St SE**
Turn **right** one block at **925 Commercial St SE** (immediately after Kearney St. S.)

<u>From West Salem - Wallace Rd</u>.
Merge onto **OR-22/Center St Bridge** via the ramp to **Salem**
Merge onto **OR-22E/ORE BUS S/Front St NE** via the ramp to **Albany**.
Turn right on **Commercial St SE** continue to **925 Commercial St SE, Ste. 320** immediately after Kearney St S.

New Patient Health Questionnaire

What is your health concern at this time and what is the reason for your visit?

_____
_____

List all prescription and non-prescription medications you take.
Patients with Diabetes: List the glucometer brand, test strip brand, and how many times you check your blood sugar in a day, if you use a pen or vial.
If you do not take any medications, write none.

****FOR PRESCRIPTION REFILLS CALL YOUR PHARMACY FIRST****

Medication: Strength: Dose:

_____
_____
_____
_____
_____
_____

****FOR PRESCRIPTION REFILLS CALL YOUR PHARMACY FIRST****

Pharmacy with location: _____

Are you allergic to any medications: YES NO
If yes, name drugs and describe reaction: _____
_____
_____

Medical History: List **all** past **surgeries**, **hospitalizations** and **illnesses**.
If none, write none.

Problem: Date: Problem: Date:

_____
_____
_____
_____
_____
_____
_____
_____
_____

If applicable, date of last:
DEXA_____ Mammogram_____ Colonoscopy_____

Health Maintenance:
Have you received your annual flu vaccination? YES NO
Date of last tetanus vaccination: _____ _____
Date of last Pneumovax (pneumonia) vaccination, if applicable: _____

Family Health

If there are no health problems, write none for which it applies to the family member. If health problem is not known for specific family member, write unknown. Under other family members list whether family member is **maternal or paternal. Names are not needed.**

List all health problems of your **blood-related family members**, along with age and cause of death. Specifically mention a history of diabetes, cancer (type), heart disease including strokes, lung disease, thyroid disease, depression or alcoholism.

Father: □ living □ deceased. Age: _____
Medical Condition: _____
_____

Mother: □ living □ deceased. Age: _____
Medical Condition: _____
_____

Sister(s): □ living □ deceased. Age(s): _____
Medical Condition: _____
_____

Brother(s): □ living □ deceased. Age(s): _____
Medical Condition: _____
_____

Son(s): □ living □ deceased. Age(s): _____
Medical Condition: _____
_____

Daughter(s): □ living □ deceased. Age(s): _____
Medical Condition: _____
_____

Other family member(s) Maternal or Paternal: □ living □ deceased. Age(s): _____
Medical Condition: _____
_____

Other family member(s) Maternal or Paternal: □ living □ deceased. Age(s): _____
Medical Condition: _____
_____

Social History

Usual Occupation (work done most of life):_____

Marital Status: Married Divorced Separated Widowed Single

Race _____ Ethnicity _____ Language _____

Who lives in your household (name, relationship, age):_____
_____

Children: YES NO Number of sons: _____ Number of daughters: _____

Use of Tobacco: YES NO FORMER SECOND-HAND
Type (circle): Chewing Cigar Cigarettes Pipe Other:_____
Amount (can/pack) per day/week/month: _____ Number of years: _____Year Quit: _____

Use of Alcohol: YES NO FORMER
Type (circle): Beer Wine Liquor Hard Liquor Methanol Other: _____
Amount (glass/bottle/can) per day/week/month: _____Year quit: _____

Use of Caffeine: YES NO
Type (circle): Coffee Soda Tea Tablets Energy drinks Chocolate Other: _____
Amount (can/oz/cup) per day/week/month: _____

Do you exercise regularly? YES NO
If yes, what exercises? _____
How many days per week? _____ How many hours per week? _____

Animals in the home: YES NO Circle: Dog Cat Bird Other (please specify):_____

Circle the items found in your home:
FIREARMS SMOKE DETECTOR FIRE EXTINGUISHERS CARBON-MONOXIDE DETECTOR

Do you use seatbelts? YES NO

Optional to answer: Do you have a religious affiliation? _____ Religion: _____
Would you like spiritual information for combating stress, depression, drug abuse or other problems? YES NO

Review of Systems
Circle New or Recent Changes and Explain

1. Chills, fever, or night sweats? _____
2. Recent change in weight? _____
3. Change in vision, smell or hearing loss? _____
4. Nasal congestion or drainage? _____
5. Voice change, difficulty swallowing or hoarseness? _____
6. Shortness of breath, cough or wheezing? _____
7. Exposure to tuberculosis? _____
8. Chest pain, swelling in the feet or ankles, irregular heart beat? _____
9. Numbness, tingling, pain or varicose veins in the lower extremities? _____
10. Constipation, diarrhea, or blood in the stool? _____
11. Nausea, vomiting, reflux or heartburn? _____
12. Pain with urination, frequent urination or waking during the night to urinate, blood in the urine, urgency or urinary incontinence? _____
13. Headaches, dizziness, light-headedness, tremors, difficulty walking or recent loss of consciousness? _____
14. Difficulty concentrating, difficulty sleeping, or frequent snoring? _____
15. Changes in skin, rashes or acne, or nail changes? _____
16. Food allergies, bee sting allergies, asthma or hay fever? _____
17. Any sexual problems you wish to discuss? _____
18. Any extra hair growth or unusual hair loss? _____
19. Muscle, back, bone or joint pain? _____
20. Swollen lymph nodes, easy bleeding or bruising? _____

Women only:

1. Date of last menstrual cycle: _____
2. Menstrual cycles: Regular or Irregular? _____
3. Do you perform regular breast self-exams? _____
4. Current form of birth control, if applicable: _____
5. Any breast discharge or lumps? _____
6. Have you ever used any type of hormone replacement? _____

Medical Information Release Form

Name: _____ Date of Birth: _____

Release of Information

[ ] Please list family or friends we have your permission to speak with regarding your medical condition and care. **Please include name and phone number.**

[ ] Spouse_____

[ ] Child(ren) _____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: _____
If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Signature: _____ Date: _____

Print Name: _____

FINANCIAL RESPONSIBILITY STATEMENT

PATIENT NAME (PLEASE PRINT) DATE OF BIRTH

Thank you for choosing Willamette Valley Endocrinology for your care. We appreciate the opportunity to serve your health care needs and look forward to getting to know you. If you have any questions or concerns, please feel free to discuss these with our staff. We provide personalized, high quality healthcare in the most cost-effective manner. This form was developed to explain and clarify our financial policies. Please read this carefully and sign where indicated. Your signature indicates that you have read and understood our policies and that you will honor the terms. We appreciate your cooperation.

Standard Payment Policy:
Co-pays for office visits are due at the time services are rendered. For your convenience, we accept Visa, Mastercard, American Express, checks, and cash. For Medicare patients, our office accepts assignment and files claims with Medicare. Medicare patients are responsible for any coinsurance and deductible amounts. Medicare patients must present their Medicare card at the time of registration. We do file secondary insurance for Medicare patients. If you are an HMP/PPO (manage care) patient of a plan in which we participate, our office has agreed to accept the plan's fee schedule and file the claim with your insurance company. HMO/PPO patients are responsible for co-pays and deductibles at the time of service. HMO/PPO patients must present their insurance card at the time of registration. HMO/PPO patients are responsible for obtaining a referral number from your primary care physician.

Payment Policy:
We file insurance claims (including Medicare) for all patients. We inform you of estimated deductibles and co-insurance amounts for exams. You will be billed for any balance due that is still remaining once insurance has paid its portion.

Assignment of Benefits:
All medical insurance benefits are paid directly to Willamette Valley Endocrinology. You are financially responsible for all the charges whether or not paid by insurance. This form authorizes Willamette Valley Endocrinology to release all information necessary to secure the payment of benefits.

Insurance Claims:
We make every effort to seek insurance reimbursement on covered services. Filing insurance in a service we provide to you; however insurance is a contract between you and your carrier. Once your insurance company has paid, you will receive a bill for any remaining balance on the account.

Collection Efforts:
We work with you to make payment arrangements. If these efforts do not result in a resolution of the account, the account may be referred to a collection agency and the local credit bureau. Any collection fees incurred by our office are charged to your account.

Returned Checks:
A service fee of $20.00 is charged on all returned checks. You will be afforded the opportunity to remit the total of the check plus the $20.00 fee in the form of cash, cashier's check, or money order on a timely basis.

Missed or Cancelled Appointments:
If you do not appear for your appointment or cancel your appointment in less than 72 hours in advance, you could be charged a $75.00 "no-show" fee. We do take into consideration emergencies for our patients.

Willamette Valley Endocrinology reserves the right to acknowledge and dismiss any patient due to continued noncompliant behavior such as disregarding healthcare instructions given by patient's provider or any harmful or disrespectful behavior to provider or staff.

I HAVE READ AND UNDERSTAND THE ABOVE AND AGREE TO COMPLY WITH THE FINANCIAL POLICIES OF WILLAMETTE VALLEY ENDOCRINOLOGY

Signature of Patient: _____ Date:_____